

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2276

CERTIFICATE OF DEATH

02261

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1210 Broadway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMMA</u> <u>AMANDA</u> <u>BARTLETT</u>				4. DATE OF DEATH Month Day Year <u>Feb</u> <u>23</u> <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 25 - 1871</u>	
9. AGE (In years lost birthday) <u>87</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Prattburg Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Drake</u>				14. MOTHER'S MAIDEN NAME <u>Julia Eaton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>72000</u>		17. INFORMANT <u>F. Ashbury Bartlett</u> Address <u>Centerville Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>421.4</u> DUE TO <u>Chronic Alcoholism</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Chronic Alcoholism</u> (b) <u>Chronic Alcoholism</u> (c) <u>Heart</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 1959</u> to <u>Feb 23 1959</u> that I last saw the deceased alive on <u>Jan 1959</u> , and that death occurred at <u>Centerville Md</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Centerville</u> DATE SIGNED <u>2/24/59</u>							
ACTUAL SIGNATURE <u>H. F. McHerson</u>		PHYSICIAN'S NAME (Type) <u>H. F. McHerson</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 26-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward J. Smith</u> ADDRESS <u>Centerville Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of coroner		11. Signature of jury		12. Signature of witnesses	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of health officer		18. Signature of local health officer		19. Signature of local health officer		20. Signature of local health officer	
21. Signature of local health officer		22. Signature of local health officer		23. Signature of local health officer		24. Signature of local health officer	
25. Signature of local health officer		26. Signature of local health officer		27. Signature of local health officer		28. Signature of local health officer	
29. Signature of local health officer		30. Signature of local health officer		31. Signature of local health officer		32. Signature of local health officer	
33. Signature of local health officer		34. Signature of local health officer		35. Signature of local health officer		36. Signature of local health officer	
37. Signature of local health officer		38. Signature of local health officer		39. Signature of local health officer		40. Signature of local health officer	
41. Signature of local health officer		42. Signature of local health officer		43. Signature of local health officer		44. Signature of local health officer	
45. Signature of local health officer		46. Signature of local health officer		47. Signature of local health officer		48. Signature of local health officer	
49. Signature of local health officer		50. Signature of local health officer		51. Signature of local health officer		52. Signature of local health officer	
53. Signature of local health officer		54. Signature of local health officer		55. Signature of local health officer		56. Signature of local health officer	
57. Signature of local health officer		58. Signature of local health officer		59. Signature of local health officer		60. Signature of local health officer	
61. Signature of local health officer		62. Signature of local health officer		63. Signature of local health officer		64. Signature of local health officer	
65. Signature of local health officer		66. Signature of local health officer		67. Signature of local health officer		68. Signature of local health officer	
69. Signature of local health officer		70. Signature of local health officer		71. Signature of local health officer		72. Signature of local health officer	
73. Signature of local health officer		74. Signature of local health officer		75. Signature of local health officer		76. Signature of local health officer	
77. Signature of local health officer		78. Signature of local health officer		79. Signature of local health officer		80. Signature of local health officer	
81. Signature of local health officer		82. Signature of local health officer		83. Signature of local health officer		84. Signature of local health officer	
85. Signature of local health officer		86. Signature of local health officer		87. Signature of local health officer		88. Signature of local health officer	
89. Signature of local health officer		90. Signature of local health officer		91. Signature of local health officer		92. Signature of local health officer	
93. Signature of local health officer		94. Signature of local health officer		95. Signature of local health officer		96. Signature of local health officer	
97. Signature of local health officer		98. Signature of local health officer		99. Signature of local health officer		100. Signature of local health officer	

MISSISSIPPI STATE DEPARTMENT OF HEALTH - BIRMINGHAM, 15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2276

CERTIFICATE OF DEATH

02262

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRASONVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STEVENSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JULIAN</u> Middle <u>COCKEY</u> Last <u>BRYAN</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>JULY 25-1884</u> 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED R.P. ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <u>74</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JULIAN E. BRYAN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA DODD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NONE</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ADLAI S. Bryan</u>		Address <u>Grasonville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adeno-carcinoma of Pancreas</u> <u>157X</u> DUE TO <u>with general Metastases in</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>liver stomach and intestine</u> DUE TO (c) <u>liver stomach and intestine</u>			INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Laparotomy Jan. 20, 1959.</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 10, 1958</u> to <u>Feb 6, 1959</u> , that I last saw the deceased alive on <u>Feb 6, 1959</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodor Sattelmaier</u> M.D.		ADDRESS (Street, city or town, State) <u>Stevensville Md.</u> DATE SIGNED <u>Feb 7, 1959</u>	
PHYSICIAN'S NAME (Type) <u>THEODOR S. TELMAIER</u>		<u>STEVENSVILLE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB. 9</u>	22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>	22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>EDGAR L. LANE</u>		24a. REC'D BY REGISTRAR <u>CHURCH HILL</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>		DATE <u>FEB 13 '59</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2277

CERTIFICATE OF DEATH

02263

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Queen Anne MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Susquehanna	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown, Penna.		c. LENGTH OF STAY IN TB 6 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION At Home RFD Chestertown		d. STREET ADDRESS 754-3	
3. NAME OF DECEASED (Type or print) Selden W. Bunnell		4. DATE OF DEATH Feb. 20 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 30, 1874
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR: Months 10 Days 10 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer owner retired		10b. KIND OF BUSINESS OR INDUSTRY Rush Township Penna.	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Bunnell		14. MOTHER'S MAIDEN NAME Almyra Kirkhoff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hugh Bunnell (Son)		Address Chestertown, Md. RFD Queen Anne Co.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio sclerotic cardio vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 6 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Nov. 19 _____, 19 58 , to Feb. 20 _____, 19 59 , that I last saw the deceased alive on Feb. 20 _____, 19 59 , and that death occurred at 2: A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE [Signature]		ADDRESS (Street, city or town, state) Chestertown, Md. DATE SIGNED 2/20/59	
PHYSICIAN'S NAME (Type) Robert W. Farr, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 24, 1959	
22c. NAME OF CEMETERY OR CREMATORY St. Patrick Cem.		22d. LOCATION (City, town, or county) (State) Middletown Township Susquehanna Co. Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR FEB 24 '59		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

1937

WILLIAM BROWN

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Marital Status		Cause of Death	
Occupation		Duration of Illness	
Place of Death		Time of Death	
Signature of Physician		Signature of Registrar	
Date of Report		Place of Report	

7-10-37

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2278
CERTIFICATE OF DEATH

02264

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>C. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Grasonville</u>		c. LENGTH OF STAY IN 1b <u>3 mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>	
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Margaretta</u> Last <u>Handy</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 11, 1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Gould</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Wilson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Arthur Handy, Cinfield, Md.</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>416X Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>See yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Influenza</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>Nov.</u> , 19 <u>58</u> , to <u>Feb.</u> , 19 <u>59</u> , that I lost the deceased alive on <u>Nov. 9</u> , 19 <u>59</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>2/11/59</u>			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/15/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grasonville Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Grasonville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kline</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>FEB 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CONFIDENTIAL

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Signature]

Enclosed for you are two copies of the report of the committee on the subject of the proposed amendment to the constitution.

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Signature]

I am, Sir, very respectfully,
Your obedient servant,
J. H. [Signature]

2279

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Q.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Queenstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Queenstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 30, 1882</u>		9. AGE (In years last birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm-tenant</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Wm. Henry Johnson</u>			
14. MOTHER'S MAIDEN NAME <u>Rebecca Stewart</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>			
16. SOCIAL SECURITY NO. <u>—</u>				17. INFORMANT <u>Willie Mae Johnson, Queenstown</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetic Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 7, 1953</u> to <u>Feb 10, 1959</u> that I last saw the deceased alive on <u>Feb 10, 1959</u> , and that death occurred at <u>1:10</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt MD</u>				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u>		DATE SIGNED <u>3/14/59</u>	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2/17/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Queenstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James R. Shill Barton, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above named matter.
I have conferred with the proper authorities and they have decided to grant your request.
I am, Sir, very respectfully,
Yours, very truly,
J. B. Smith
Secretary

2280

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Queenstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural-Queenstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bishop</u> Middle <u>—</u> Last <u>Lister</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>24</u> Year <u>1959</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 6, 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Willard Thomas Lister</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Dolilah Haines</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> If yes, give war or dates of service <u>—</u>				16. SOCIAL SECURITY NO. <u>215-36-0277</u>		INFORMANT <u>Mrs. Bishop Lister</u> Address <u>Queenstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Larynx</u> <u>161X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>9 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>59</u> , to <u>Feb</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb. 16</u> , 19 <u>59</u> , and that death occurred at <u>9:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.				ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>2/24/59</u>			
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chesterfield</u>		22d. LOCATION (City, town, or county) (State) <u>Chesterfield Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Edward Becking, Bethel, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haines</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/58

State of New York
County of Albany

I, the undersigned, a Justice of the Peace for the County of Albany, do hereby certify that

the within and foregoing is a true and correct copy of the original of the same as the same appears from the records of the County of Albany.

In testimony whereof, I have hereunto set my hand and the seal of the County of Albany, at Albany, New York, this 1st day of January, 1901.

Justice of the Peace for the County of Albany

Notary Public for the County of Albany

Subscribed and sworn to before me this 1st day of January, 1901.

Notary Public for the County of Albany

Attest my hand and the seal of the County of Albany, at Albany, New York, this 1st day of January, 1901.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2281

CERTIFICATE OF DEATH

Reg. Dist. No.

02267

1. PLACE OF DEATH a. COUNTY <u>QUEEN ANNE'S</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>QUEEN ANNE'S</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centerville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Edmund Carville</u> First Middle Last		4. DATE OF DEATH Month <u>Feb.</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1873</u>
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hardware</u>	
11. BIRTHPLACE (State or foreign country) <u>Carville Station, P.A.C., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wrightson Lambdin Lowe</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Catherine Carville</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mr. James R. Friel, Queenstown, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Deobasis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> <u>Generalis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 or 4 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1st</u> , 19 <u>50</u> , to <u>Feb. 2nd</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Jan. 31</u> , 19 <u>54</u> , and that death occurred at <u>8:10</u> a.m., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. F. McPherson</u>		DATE SIGNED <u>2-2-59</u>	
PHYSICIAN'S NAME (Type) <u>H. F. McPherson</u>		ADDRESS (Street, city or town, state) <u>Centerville Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 4, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Butler, Jr., Baltimore, Centerville, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

Page No. 10

<p>NAME OF DECEASED [Faint, illegible text]</p>		<p>AGE [Faint, illegible text]</p>	
<p>SEX [Faint, illegible text]</p>		<p>DATE OF BIRTH [Faint, illegible text]</p>	
<p>PLACE OF BIRTH [Faint, illegible text]</p>		<p>DATE OF DEATH [Faint, illegible text]</p>	
<p>CAUSE OF DEATH [Faint, illegible text]</p>		<p>PLACE OF DEATH [Faint, illegible text]</p>	
<p>DATE OF INTERMENT [Faint, illegible text]</p>		<p>PLACE OF INTERMENT [Faint, illegible text]</p>	
<p>SIGNATURE OF DECEASED [Faint, illegible text]</p>		<p>SIGNATURE OF WITNESSES [Faint, illegible text]</p>	
<p>SIGNATURE OF PHYSICIAN [Faint, illegible text]</p>		<p>SIGNATURE OF CLERK [Faint, illegible text]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2282

CERTIFICATE OF DEATH

02268

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's County</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CENTREVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CENTREVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				1. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>C.</u> Last <u>Pusey</u>				4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-15-1871</u>		9. AGE (In years last birthday) yrs. <u>87</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr. Burton W. Hurley</u>				14. MOTHER'S MAIDEN NAME <u>Mary W. O'Bier</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Alyce P. Hammond (daughter), Centreville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Secondary anemia</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Latent malignancy</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u> <u>(?)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized atherosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1950</u> , to <u>15 Feb 1959</u> , that I last saw the deceased alive on <u>11 Feb 1959</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Centreville, Maryland</u> <u>16 Feb 59</u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON EASTON, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB 18</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>		22d. LOCATION (City, town, or county) (State) <u>SEAFORD DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>				ADDRESS <u>Church Hill Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 19 59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kroma</u>			

CERTIFICATE OF DEATH

2282

<p>1. Name of deceased: <u>JOHN J. BROWN</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>1915</u></p>		<p>4. Date of death: <u>1975</u></p>	
<p>5. Place of birth: <u>NEW YORK</u></p>		<p>6. Place of death: <u>NEW YORK</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Immediate cause: <u>Myocardial Infarction</u></p>	
<p>9. Underlying cause: <u>Coronary Artery Disease</u></p>		<p>10. Contributing cause: <u>None</u></p>	
<p>11. Duration of illness: <u>Several months</u></p>		<p>12. Date of onset: <u>1974</u></p>	
<p>13. Date of admission to hospital: <u>1974</u></p>		<p>14. Date of discharge: <u>1974</u></p>	
<p>15. Name of attending physician: <u>Dr. J. Smith</u></p>		<p>16. Name of certifying physician: <u>Dr. J. Smith</u></p>	
<p>17. Name of medical examiner: <u>Dr. J. Smith</u></p>		<p>18. Name of pathologist: <u>Dr. J. Smith</u></p>	
<p>19. Name of funeral home: <u>None</u></p>		<p>20. Name of cemetery: <u>None</u></p>	
<p>21. Name of next of kin: <u>None</u></p>		<p>22. Name of informant: <u>None</u></p>	
<p>23. Name of informant: <u>None</u></p>		<p>24. Name of informant: <u>None</u></p>	
<p>25. Name of informant: <u>None</u></p>		<p>26. Name of informant: <u>None</u></p>	
<p>27. Name of informant: <u>None</u></p>		<p>28. Name of informant: <u>None</u></p>	
<p>29. Name of informant: <u>None</u></p>		<p>30. Name of informant: <u>None</u></p>	
<p>31. Name of informant: <u>None</u></p>		<p>32. Name of informant: <u>None</u></p>	
<p>33. Name of informant: <u>None</u></p>		<p>34. Name of informant: <u>None</u></p>	
<p>35. Name of informant: <u>None</u></p>		<p>36. Name of informant: <u>None</u></p>	
<p>37. Name of informant: <u>None</u></p>		<p>38. Name of informant: <u>None</u></p>	
<p>39. Name of informant: <u>None</u></p>		<p>40. Name of informant: <u>None</u></p>	
<p>41. Name of informant: <u>None</u></p>		<p>42. Name of informant: <u>None</u></p>	
<p>43. Name of informant: <u>None</u></p>		<p>44. Name of informant: <u>None</u></p>	
<p>45. Name of informant: <u>None</u></p>		<p>46. Name of informant: <u>None</u></p>	
<p>47. Name of informant: <u>None</u></p>		<p>48. Name of informant: <u>None</u></p>	
<p>49. Name of informant: <u>None</u></p>		<p>50. Name of informant: <u>None</u></p>	
<p>51. Name of informant: <u>None</u></p>		<p>52. Name of informant: <u>None</u></p>	
<p>53. Name of informant: <u>None</u></p>		<p>54. Name of informant: <u>None</u></p>	
<p>55. Name of informant: <u>None</u></p>		<p>56. Name of informant: <u>None</u></p>	
<p>57. Name of informant: <u>None</u></p>		<p>58. Name of informant: <u>None</u></p>	
<p>59. Name of informant: <u>None</u></p>		<p>60. Name of informant: <u>None</u></p>	
<p>61. Name of informant: <u>None</u></p>		<p>62. Name of informant: <u>None</u></p>	
<p>63. Name of informant: <u>None</u></p>		<p>64. Name of informant: <u>None</u></p>	
<p>65. Name of informant: <u>None</u></p>		<p>66. Name of informant: <u>None</u></p>	
<p>67. Name of informant: <u>None</u></p>		<p>68. Name of informant: <u>None</u></p>	
<p>69. Name of informant: <u>None</u></p>		<p>70. Name of informant: <u>None</u></p>	
<p>71. Name of informant: <u>None</u></p>		<p>72. Name of informant: <u>None</u></p>	
<p>73. Name of informant: <u>None</u></p>		<p>74. Name of informant: <u>None</u></p>	
<p>75. Name of informant: <u>None</u></p>		<p>76. Name of informant: <u>None</u></p>	
<p>77. Name of informant: <u>None</u></p>		<p>78. Name of informant: <u>None</u></p>	
<p>79. Name of informant: <u>None</u></p>		<p>80. Name of informant: <u>None</u></p>	
<p>81. Name of informant: <u>None</u></p>		<p>82. Name of informant: <u>None</u></p>	
<p>83. Name of informant: <u>None</u></p>		<p>84. Name of informant: <u>None</u></p>	
<p>85. Name of informant: <u>None</u></p>		<p>86. Name of informant: <u>None</u></p>	
<p>87. Name of informant: <u>None</u></p>		<p>88. Name of informant: <u>None</u></p>	
<p>89. Name of informant: <u>None</u></p>		<p>90. Name of informant: <u>None</u></p>	
<p>91. Name of informant: <u>None</u></p>		<p>92. Name of informant: <u>None</u></p>	
<p>93. Name of informant: <u>None</u></p>		<p>94. Name of informant: <u>None</u></p>	
<p>95. Name of informant: <u>None</u></p>		<p>96. Name of informant: <u>None</u></p>	
<p>97. Name of informant: <u>None</u></p>		<p>98. Name of informant: <u>None</u></p>	
<p>99. Name of informant: <u>None</u></p>		<p>100. Name of informant: <u>None</u></p>	

ORIGINAL FILED

1. Name of deceased: JOHN J. BROWN
 2. Sex: Male
 3. Date of birth: 1915
 4. Date of death: 1975
 5. Place of birth: NEW YORK
 6. Place of death: NEW YORK
 7. Cause of death: Heart Disease
 8. Immediate cause: Myocardial Infarction
 9. Underlying cause: Coronary Artery Disease
 10. Contributing cause: None
 11. Duration of illness: Several months
 12. Date of onset: 1974
 13. Date of admission to hospital: 1974
 14. Date of discharge: 1974
 15. Name of attending physician: Dr. J. Smith
 16. Name of certifying physician: Dr. J. Smith
 17. Name of medical examiner: Dr. J. Smith
 18. Name of pathologist: Dr. J. Smith
 19. Name of funeral home: None
 20. Name of cemetery: None
 21. Name of next of kin: None
 22. Name of informant: None
 23. Name of informant: None
 24. Name of informant: None
 25. Name of informant: None
 26. Name of informant: None
 27. Name of informant: None
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 93. Name of informant: None
 94. Name of informant: None
 95. Name of informant: None
 96. Name of informant: None
 97. Name of informant: None
 98. Name of informant: None
 99. Name of informant: None
 100. Name of informant: None

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2283

CERTIFICATE OF DEATH

Reg. Dist. No.

02269

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brumplow</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall 14x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>MARY C.</u> Middle <u>RYAN</u> Last <u>ROBINSON</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>27</u> Year <u>1959</u>			
5. SEX <u>FEM</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 23-1876</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>EDWARD PROCTOR</u>				14. MOTHER'S MAIDEN NAME <u>LENA DAVIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Abram Bryden-Rock Hall, Ind.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dilatation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Myocarditis</u> (c) <u>General Arterial Sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoked</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>no</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 26, 1958</u> , to <u>Feb 27, 1959</u> , that I last saw the deceased alive on <u>Feb 26, 1959</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>C. W. Whitehead</u> M.D.				ADDRESS (Street, city or town, state) <u>Lynchville</u> DATE SIGNED <u>2/25/59</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 2</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Rock Hall MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar H. Lane</u> ADDRESS <u>Church Hill Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

CERTIFICATE OF DEATH

2283

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928	
PLACE OF BIRTH		OCCUPATION		EDUCATION		MARRIAGE	
MEMPHIS, TENN.		ATTORNEY		HIGH SCHOOL		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
APR 4 1968		MEMPHIS, TENN.		HEART DISEASE		NATURAL	
TIME OF DEATH		HOURS		MINUTES		SECONDS	
10:00 AM		10		00		00	
DATE OF REPORT		PLACE OF REPORT		REPORTED BY		TITLE	
APR 4 1968		MEMPHIS, TENN.		JAMES EARL RAY		ATTORNEY	
SIGNATURE OF REPORTER		DATE OF SIGNATURE		SIGNATURE OF WITNESS		DATE OF SIGNATURE	
JAMES EARL RAY		APR 4 1968		JAMES EARL RAY		APR 4 1968	
TITLE		DATE OF TITLE		TITLE		DATE OF TITLE	
ATTORNEY		APR 4 1968		ATTORNEY		APR 4 1968	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
APR 4 1968		MEMPHIS, TENN.		HEART DISEASE		NATURAL	
TIME OF DEATH		HOURS		MINUTES		SECONDS	
10:00 AM		10		00		00	
DATE OF REPORT		PLACE OF REPORT		REPORTED BY		TITLE	
APR 4 1968		MEMPHIS, TENN.		JAMES EARL RAY		ATTORNEY	
SIGNATURE OF REPORTER		DATE OF SIGNATURE		SIGNATURE OF WITNESS		DATE OF SIGNATURE	
JAMES EARL RAY		APR 4 1968		JAMES EARL RAY		APR 4 1968	
TITLE		DATE OF TITLE		TITLE		DATE OF TITLE	
ATTORNEY		APR 4 1968		ATTORNEY		APR 4 1968	

CERTIFICATE OF DEATH

Reg. Dist. No.

02270

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Bessie</u> First <u>mac</u> Middle <u>Whittico</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/8/05</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR: Months <u>53</u> Days <u>53</u> Hours <u>53</u> Min. <u>53</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John Whittico</u>		14. MOTHER'S MAIDEN NAME <u>Annie Green</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>219-071386</u>	
17. INFORMANT <u>—</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>481X</u> DUE TO <u>Inflamed Type</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>not determined</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 20, 1959</u> to <u>Feb 20, 1959</u> , that I last saw the deceased alive on <u>Feb 20, 1959</u> , and that death occurred at <u>2:26 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. R. Layton</u> M.D.		ADDRESS (Street, city or town, state) <u>104 S Liberty St Centreville Md</u> DATE SIGNED <u>2-26-59</u>	
PHYSICIAN'S NAME (Type) <u>C. R. Layton</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chartersfield Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Centreville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Doherty</u> ADDRESS <u>Centreville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 5 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NEWYORK STATE DEPARTMENT OF HEALTH - BALTHAMORE 11

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2285 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02271

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Queen Anne b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barclay c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At home		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barclay, Maryland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Calvert S. Wilson		4. DATE OF DEATH Feb. 25, 1959	
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1923
9. AGE (in years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Laborer	
11. BIRTHPLACE (State or foreign country) Queen Anne Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph H. Wilson		14. MOTHER'S MAIDEN NAME Blanche Johnson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes (Jun. 1944 to 1946)		16. SOCIAL SECURITY NO. SS (218-20-7241)	
17. INFORMANT Helen Wilson		Address Barclay, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 353.3 Consultation perhaps Chaperlain DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Henry Fisher		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Continued Ind		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/28/59	22c. NAME OF CEMETERY OR CREMATORY Barclay Cemetery	22d. LOCATION (City, town, or county) (State) Barclay, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Kenneth Waller		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR MAR 3 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

FOR STATE
HEALTH DEPT.

STATE OF TEXAS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Manner of Death: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Registrar: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2286 Item 9 Film G239 2-20-59 et
CERTIFICATE OF DEATH

Reg. Dist. No.

02272

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) c. STATE <u>MARYLAND</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queens town</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>X Queens town</u>	
3. NAME OF DECEASED (Type or print) <u>Samuel</u> First <u>Wilson</u> Middle <u>Wilson</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>3</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/85</u>
9. AGE (In years last birthday) <u>73 7/12</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>12</u> Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Charles Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>George H. Wilson, Queens town</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>? yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>57</u> , to <u>Feb.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Feb 1</u> , 19 <u>59</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Irvin D. Hoyt</u> M.D.		ADDRESS (Street, city or town, state) <u>Seesonsburg, Md</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/8/59</u>	<u>Grassonville Cam</u>	<u>Grassonville, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James D. Doolittle, Canton, Md</u> ADDRESS		24a. REC'D BY REGISTRAR <u>FEB 16 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

